General Assembly

Raised Bill No. 491

February Session, 2008

LCO No. **2299**

02299_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING MEDICAL LOSS RATIOS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

As used in sections 38a-478 to 38a-478o, inclusive, and subsection (a) of section 38a-478s:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Managed care organization" means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing, **[**or**]** amending or continuing any individual or group health managed care plan in this state.

(3) "Managed care plan" means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and

procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and that the plan includes utilization review pursuant to sections 38a-226 to 38a-226d, inclusive.

(4) "Provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

(5) Except as provided in sections 38a-478m and 38a-478n of the 2008 supplement to the general statutes, "enrollee" means a person who has contracted for or who participates in a managed care plan for himself or his eligible dependents.

(6) "Preferred provider network" means a preferred provider network, as defined in section 38a-479aa of the 2008 supplement to the general statutes.

(7) "Utilization review" means utilization review, as defined in section 38a-226.

(8) "Utilization review company" means a utilization review company, as defined in section 38a-226.

(9) "Medical loss ratio" means the ratio of direct claims incurred to direct premiums earned during the preceding calendar year for each individual and group health insurance product line delivered, issued for delivery, renewed, amended or continued by a managed care organization in the state.

(10) "Direct claims incurred" means actual claims incurred by the managed care organization, including actual claims incurred by subcontractors to the managed care organization under a capitated at-risk arrangement. "Direct claims incurred" shall not include expenses for stop loss, reinsurance, enrollee educational programs or cost

containment programs or features for the managed care organization or any of its subcontractors.

Sec. 2. (NEW) (*Effective January 1, 2009*) (a) No managed care organization shall have a medical loss ratio of less than eighty-seven and one-half per cent.

(b) The medical loss ratio specified in subsection (a) of this section shall not apply to subsection (b) of section 38a-495 of the general statutes, subsection (b) of section 38a-501 of the 2008 supplement to the general statutes, subsection (b) of section 38a-522 of the general statutes, subsection (b) of section 38a-528 of the general statutes, subdivision (3) of subsection (b) of section 38a-565 of the 2008 supplement to the general statutes and subdivision (1) of section 38a-570 of the 2008 supplement to the general statutes.

Sec. 3. Section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(a) On or before May 1, 1998, and annually thereafter, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization

review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July 1, 1998, and annually thereafter, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

(2) A report on its medical loss ratio that includes, but is not limited to: (A) The total number of enrollees; (B) its medical loss ratio; (C) the total in dollars of direct premiums earned; (D) the total in dollars of direct claims incurred by each capitated subcontracted entity by subcontract; (E) its administrative expenses, including, but not limited to, administrative costs directly incurred by the managed care organization, by each of its subcontractors and total administrative expenses; and (F) the margin or profit earned by the managed care organization in dollars and as a percentage of the premium dollars earned. For the purpose of this subdivision, "administrative expenses" shall not include capitation payments to capitated at-risk managed care organization subcontractors.

[(2)**]** (3) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary

fee schedule information.

[(3)**]** (4) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians, preferred provider networks and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a risk-sharing arrangement or a capitated risk arrangement.

[(4)**]** (5) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l* of the 2008 supplement to the general statutes. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its medical loss ratio or percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing, how it compensates health care providers and its premium level; (C) a description of services, the number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and **[**speciality**]** specialty care provider, the percentage of primary and **[**speciality**]** specialty care providers who are board certified, and how the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this

section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner.

[(5)**]** (6) A summary of the procedures used by managed care organizations to credential providers.

(b) The information required pursuant to subsection (a) of this section shall be consistent with the data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS).

(c) The commissioner may accept electronic filing for any of the requirements under this section.

(d) No managed care organization shall be liable for a claim arising out of the submission of any information concerning complaints concerning providers, provided the managed care organization submitted the information in good faith.

Sec. 4. Subsection (b) of section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2009*):

(b) Each managed care organization shall provide every enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with chapter 699a. The plan description shall be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

(1) A clear summary of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (a) of this section, subdivision **[**(3)**]** (4) of subsection (a) of section 38a-478c, as amended by this act, and sections

38a-478j to 38a-478*l*, inclusive, of the 2008 supplement to the general statutes;

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

(3) A description of emergency services, the appropriate use of emergency services, including to the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in which participating physicians and hospitals provide emergency services and post stabilization care;

(4) Coverage of the plans, including exclusions of specific conditions, ailments or disorders;

(5) The use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered;

(6) The number, types and specialties and geographic distribution of direct health care providers;

(7) Participating and nonparticipating provider reimbursement procedure;

(8) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

(9) The medical loss ratio, or percentage of total premium revenue spent on medical care compared to administrative costs and plan marketing;

(10) The plan's for-profit, nonprofit incorporation and ownership status;

(11) Telephone numbers for obtaining further information, including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

(12) How notification is provided to an enrollee when the plan is no longer contracting with an enrollee's primary care provider;

(13) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

(14) The status of the National Committee for Quality Assurance (NCQA) accreditation;

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2009*	38a-478
Sec. 2	*January 1, 2009*	New section
Sec. 3	*January 1, 2009*	38a-478c
Sec. 4	*January 1, 2009*	38a-478g(b)

Statement of Purpose:

To require managed care organizations to have a medical loss ratio of not less than eighty-seven and one-half per cent, and to require annual reporting of medical loss ratio data to the Insurance Commissioner.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]